

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-013569

FILED MAY 1 1959

Registration District No. 149 Primary Registration District No. 1002

STATE FILE NUMBER 1862
Registrar's No.

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 7332 Walnut St.		d. STREET ADDRESS (If outside, give location) 7332 Walnut St.	
3. NAME OF DECEASED (Type or print) First Thomas Middle Benjamin Last Sydenstricker		4. DATE OF DEATH Month April Day 12 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 2, 1903
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. Mgr. Southwest News Co.		11. BIRTHPLACE (City and state or country) Slater, Mo.	
13a. FATHER'S NAME David T. Sydenstricker		13b. MOTHER'S MAIDEN NAME Minnie Hawkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		17. INFORMANT Address Ronald W. Doyle 1309 East 83rd Street	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Robert Quennorn			19. WAS AUTOPSY PERFORMED? 1 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from _____, to _____ and last saw her alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Hugh H. Owens		22b. ADDRESS 1034 Chaffin Bldg.	22c. DATE SIGNED 4-13-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried	23b. DATE 4-14-59	23c. NAME OF CEMETERY OR CREMATORY Mt. Moriah	23d. LOCATION (City, town, or county) (State) K.C. Mo.
24. FUNERAL DIRECTOR ADDRESS D.W. Nerukomis Sons		25. DATE RECD. BY LOCAL REG. 4-13-59	26. REGISTRAR'S SIGNATURE Reva Marshall

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Hugh H. Owens

24

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Basil V. Abney

Licensed Embalmer No. 4724
P. O. Address A. C. 9110

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.

34